UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

NEUROLOGICAL SURGERY PRACTICE OF LONG ISLAND, PLLC,

Plaintiff,

vs

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF THE TREASURY; UNITED STATES DEPARTMENT OF LABOR; XAVIER BECERRA, in his official capacity as Secretary, United States Department of Health and Human Services; JANET YELLEN, in her official capacity as Secretary, United States Department of the Treasury; and JULIE A. SU, in her official capacity as Acting Secretary, United States Department of Labor,

Defendants.

Case No. 1:23-cv-2977

Hon. Brian M. Cogan

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF INJUNCTIVE RELIEF

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Plaintiff, Neurological Surgery Practice of Long Island, PLLC (the "Practice" or "Plaintiff"), submits this memorandum of law in support of its application for an Order pursuant to Rule 65 of the Federal Rules of Civil Procedure mandating that Defendants, United States Department of Health and Human Services; United States Department of the Treasury; United States Department of Labor; Xavier Becerra, in his official capacity as Secretary, United States Department of Health and Human Services; Janet Yellen, in her official capacity as Secretary, United States Department of the Treasury; and Julie A. Su, in her official capacity as Acting Secretary, and United States Department of Labor (collectively, the "Departments" or "Defendants") during the pendency of this lawsuit:

a. Direct health plans subject to the No Surprises Act to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan, and enforce compliance with this direction;

b. Direct health plans subject to the No Surprises Act to make all initial payments under the No Surprises Act to the out-of-network providers who rendered the medical services, as opposed to the patients, and monitor compliance with this direction;

c. Direct health plans subject to the No Surprises Act to ensure that (i) the explanation of benefits (EOB) forms required by the No Surprises Act be sent to the out-of-network providers who rendered the medical services; (ii) these EOBs clearly indicate the issuing health plan's understanding whether the case is eligible for independent dispute resolution (IDR) under either federal or state law; and (iii) the EOBs report the health plans' proposed qualified payment amount (as defined according to the No Surprises Act) for each CPT code reflected on the EOB, and monitor compliance with these directions.

d. Devote sufficient monetary and other resources required to ensure that the IDR process time frames established by the No Surprises Act are complied with;

e. Direct health plans to take all steps necessary to ensure that the IDR process time frames established by the No Surprises Act are complied with, and monitor compliance with these directions;

f. Establish a streamlined process for determining threshold eligibility issues, along with providing an explanation for why a dispute is eligible or ineligible for IDR so as to eliminate roadblocks in the IDR processing system;

g. Allow a reasonable batching of similarly situated IDR claims;

h. Follow the provisions of the No Surprises Act and require that reimbursement disputes relating to elective procedures performed in a New York state-located hospital, by an out-of-network provider, on a fully insured or otherwise state regulated health plan beneficiary, who was aware before he or she came to the hospital that the provider was out of network, but chose to proceed anyway, be accepted by and decided through federal IDR process;

i. Direct health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the No Surprises Act, and monitor compliance with this direction; and

j. Require Defendants to provide a status report to the Court weekly regarding compliance with this Order.

PRELIMINARY STATEMENT

The Practice is one of the largest private neurosurgery practices in New York. Like many other independent medical specialty groups, the Practice has chosen in most cases not to join health plan networks because its relatively small size has made it historically impossible to negotiate acceptable rates. Notwithstanding this, however, the Practice regularly provides medically necessary services on an out-of-network basis to enrollees of all the major health plans. The Practice's provision of these services since January 2022 has been governed in most cases by the No Surprises Act, 42 U.S.C. §§ 300gg-111, *et seq.*

Under the No Surprises Act, out-of-network providers, such as the Practice, are prohibited from billing or collecting from patients for their services. Rather, the health plans have the authority to unilaterally determine, in the first instance, whether, and what amount, to pay for the services. The providers only recourse is, if they dispute the health plans' non-payment or low payment, to use the independent dispute resolution (IDR) process established by the Act. This process was based largely on the "baseball-style" arbitration process first used in New York in its Surprise Bill Law, ad is designed to be an expeditious, efficient, and fair process.

For the Practice and other similarly situated out-of-network providers, many of their patient encounters are governed by the No Surprises Act. And, because health plans, when they pay at all, have unilaterally decided to pay providers under the Act at rates far below what they have historically paid – and far below the providers' costs for rendering the services – the Practice and other similarly situated out-of-network providers are heavily dependent on an expeditious, efficient, and fair IDR process to avoid grievous and irreparable harm.

Yet, as the accompanying papers explain, the IDR process has been anything but expeditious, efficient, or fair. And, as the accompanying papers further allege, the Defendants have failed in their statutory obligations to properly implement the No Surprises Act and protect the Practice and other similarly situated out-of-network providers and require plans' adherence to the strict statutory timelines and non-discretionary duties established by the Act.

The Defendants' unlawful implementation of the No Surprises Act has put the Practice and other similarly situated out-of-network providers in jeopardy of imminent financial collapse. This will have a disastrous impact on healthcare access, quality, and cost. It will also create significant and irreparable financial losses for the providers due to the destruction of their practices. As a result, and for the following reasons, the Practice has demonstrated a likelihood of success on the merits, irreparable harm in the absence of preliminary relief, that the balance of equities tips in the Practice's favor, and that an injunction is in the public interest.

STATEMENT OF FACTS

This Memorandum of Law incorporates by reference the facts set forth in the Declaration of Michael H. Brisman, M.D. and the facts outlined in the Complaint. In the interests of brevity and efficiency, the facts set forth in those documents will not be repeated herein.

RELEVANT STANDARDS OF REVIEW

A preliminary injunction is warranted when a party demonstrates (1) a clear or substantial likelihood of success on the merits; (2) irreparable harm absent injunctive relief; and, (3) that the public's interest weighs in favor of granting an injunction. *Red Earth LLC v. United States*, 657 F.3d 138, 143 (2d Cir. 2011); *Doninger v. Niehoff*, 527 F.3d 41, 47 (2d Cir. 2008); *see also Winter v. Natural Res. Def. Council, Inc*., 555 U.S. 7, 20 (2008) ("A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.")

However, the "clear or substantial" likelihood of success (as opposed to just a likelihood of success) is only required in two instances. The Second Circuit has explained:

> The moving party must make a "clear" or "substantial" showing of a likelihood of success where (1) the injunction sought "will alter, rather than maintain, the status quo" — *i.e.,* is properly characterized as a "mandatory" rather than "prohibitory" injunction; or (2) the injunction sought "will provide the movant with substantially all the relief sought, and that relief cannot be undone even if the defendant prevails at a trial on the merits."

Jolly v. Coughlin, 76 F. 3d 468, 474 (2d Cir. 1996) (*citing Tom Doherty Assocs., Inc. v. Saban Entertainment, Inc.,* 60 F.3d 27, 33-34 (2d Cir. 1995)). *overruled on other grounds*, *City of Boerne v. Flores*, 521 U.S. 507, 117 S.Ct. 2157, 138 L.Ed.2d 624 (1997). In other words, where the injunction sought is prohibitory, and does not alter the status quo, the higher level of "clear or substantial" is not required.

A court "need not find with 'absolute certainty' that Plaintiff will succeed on the merits of their claims," but rather that Plaintiff has "more than a fifty-fifty chance of succeeding." *RxUSA Wholesale, Inc. v. Department of Health and Human Servs.*, 467 F.Supp.2d 285, 300 (E.D.N.Y.

2006) (citing *Wali v. Coughlin*, 754 F.2d 1015, 1025 (2d Cir. 1984) ("A movant . . . need only make a showing that the probability of his prevailing is better than fifty percent. There may remain considerable room for doubt").

Section 702 of the APA plainly states that "[a] person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof." 5 U.S.C. 702. Section 706, the APA provision principally at issue in this case, defines the scope of such review. As relevant here, Section 706 states that "[t]he reviewing court shall—(1) compel agency action unlawfully withheld or unreasonably delayed; and (2) hold unlawful and set aside agency action, findings, and conclusions found to be," inter alia, "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."5 U.S.C. 706. Plaintiff is entitled to a declaration and a writ of prohibition or mandamus for Defendants' violation of the No Surprises Act. *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 327 (2015) (it is axiomatic that federal courts may "grant injunctive relief against state officers who are violating, or planning to violate, federal law. But that has been true not only with respect to violations of federal law by state officials, ***but also with respect to violations of federal law by federal officials***) (emphasis added).

ARGUMENT

I. DEFENDANTS' CONDUCT WILL CAUSE IRREPARABLE HARM WITHOUT AN INJUNCTION

The Practice provides medically necessary health care services, as defined by the No Surprises Act, to health plan beneficiaries. The Practice relies on consistent, fair rates of reimbursement to be able to continuously provide high quality care to the patients they treat. The Departments failure to adhere to the Act's requirements and, also enforce compliance with the IDR process have caused significant, irreparable harm.

The very purpose of the No Surprises Act was to prevent patients from having responsibility for medical bills from non-contracted medical providers with whom their private health plans had failed to reach adequate payment agreements. To solve this problem, the No Surprises Act prohibits out-of-network providers, such as the Practice, from balance billing or otherwise pursuing payments from health plan members. *See* 42 U.S.C. §§ 300gg-131(a) (emergency services), 300gg-132 (non-emergency services performed by nonparticipating providers at participating facilities). Given this balance billing ban, the Act requires health plans, within 30 calendar days after the out-of-network provider transmits its bill to the health plan, to either make an initial payment to the provider or issue a notice of denial of payment. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I)

The Practice, and other similarly situated out-of-network providers, are heavily dependent upon the effectiveness, timeliness, and efficiency of the federal IDR process established by the No Surprises Act to "level the playing field" with the plans and ensure that the providers receive if not reasonable compensation for their services, at least compensation for their services that covers the costs for providing those services.

Unfortunately, as outlined in the Declaration of Michael H. Brisman, M.D., the Departments have failed to honor their statutory obligations under the No Surprises Act and have thereby destroyed the timeliness, effectiveness, and efficiency of the federal IDR process. As but one example, there have been numerous claims involving medical services provided by the Practice to enrollees of the plans for which (a) an IDR proceeding was commenced; (b) the duly appointed IDR entity, after reviewing the parties' offers and submissions, selected the Practice's offers, resulting in an additional reimbursement due from the plans to the Practice; (c) more than 30 days have elapsed since the IDR entity made these determinations; yet (d) the plans have

breached their statutory obligation under 42 U.S.C. § 300gg-111(c)(6) to pay these additional reimbursement amounts. *See* Brisman Decl., Exhibit A.

In fact, a recent study conducted by the Emergency Department Practice Management Association ("EPDMA") confirmed that the Practice's experience concerning the IDR process has been felt by providers nationwide.[1] The EDPMA study results showed:

- 68 percent of filed IDR claims did not receive a response from the insurance payers during their 30-day open negotiation period
- 52 percent of filed IDR claims didn't even acknowledge that an IDR case had been filed
- 91 percent of open claims remain open and unadjudicated
- 95 percent of outstanding claims are 5 or more months old
- 87 percent of payers did not pay in accordance with the IDR determination

As a consequence, and because of the balance billing ban imposed by the Act, each day that the health plans fail to comply with the 30-day deadline marks yet another day that the Practice does not get paid *anything* for the medically necessary treatment that it provided to the health plan's beneficiaries. The inefficiencies of the federal IDR process – created by the Departments' failure to mandate the health plans adherence to the No Surprises Act – have also greatly increased the providers' revenue cycle costs, at a time when reimbursements have been drastically cut. *See* Brisman Decl. ¶¶ 57-58.

This record establishes irreparable injury. *See Kelco Disposal, Inc. v. Browning Ferris Indus.*, 845 F2d 404, 408 (2d Cir. 1988) (recognizing that consistently low prices will drive businesses from market); *see also Semmes Motor Co. v. Ford Motor Co.*, 429 F.2d 1197 (2d Cir.

[1] *See* https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf (last accessed on May 10, 2023).

1970) (court upheld issuance preliminary injunction where defendant's actions would destroy plaintiff's business); *see also Henderson v. Bodine Aluminum, Inc.*, 70 F3d 958, 961 (8th Cir. 1995) ("It is hard to imagine a greater harm than losing a chance for potentially life-saving medical treatment"); *United Steelworkers of Amer. v. Textron, Inc.*, 836 F.2d 6, 8 (1st Cir. 1987); *Samele v. Zucker*, 324 F. Supp3d 313, 333 (E.D.N.Y. 2018) ("Loss of medical care constitutes irreparable harm").

Put simply, to maintain a sufficient level of high-quality health care in this nation, Defendants must compel health plans to adhere to the No Surprises Act. *See* Brisman Decl. ¶¶ 59-60. If not, the consequences that patients and Plan enrollees will suffer include the loss of continuity of medical care, significant delays in the provision of care due to the lack of or restricted access to out-of-network physicians, potential exposures to surprise and balance bills, and significant increases in adverse health outcomes, including serious illness and the potential loss of life. *Id.*; See *Fairfield County Med. Ass'n v. United Healthcare of New Eng.*, 985 F. Supp. 2d 262, 271 (D. Conn 2013) (several district and circuit courts have found that disruption of the physician-patient relationship can cause irreparable harm that justifies issuing preliminary injunctive relief).

This can be avoided simply by ordering the Departments to honor the mandates, including, but not limited to, the specific time requirements outlined in the No Surprises Act. This would only serve to preserve the status quo and ensure that providers are being timely reimbursed when prevailing at the IDR. Moreover, requiring health plans to adhere to the No Surprises Act good faith negotiation requirements might obviate the need for a dispute to be submitted to the IDR, which would save time, money and reduce the burden to the IDR entities by decreasing the volume of claims submitted for a resolution. This simple act will compel health plans to honor their

commitments and provide for the fast adjudication and payment for emergency medical services where appropriate.

In the time that it will take for this case to proceed through discovery and trial, many out-of-network physician practices will be driven out of the market because of Defendants' actions, and those that remain will have significantly reduced or eliminated their services. Any monetary recovery, therefore, will be "too little, too late" to recompense the out-of-network physicians, including the Practice for Defendants' wrongful conduct.

The financial bleeding, accordingly, must be stopped now. As stated in *Semmes*:

> Ford's contention that Semmes failed to show irreparable injury from termination is wholly unpersuasive. Of course, Semmes' past profits would afford a basis for calculating damages for wrongful termination, and no one doubts Ford's ability to respond. But the right to continue a business in which William Semmes had engaged for twenty years and into which his son had recently entered is not measurable entirely in monetary terms; **the Semmes want to sell automobiles, not to live on the income from a damage award.**

Semmes, 429 F2d at 1205 (emphasis added).

Any award of retroactively increased reimbursement will do *nothing* to recompense the Practice for the disruption to their practice. This harm is not reparable through increased reimbursement. Further, retroactive award will not allow the Practice to rehire terminated staff who have taken positions elsewhere nor re-establish terminated or divested elements of their practices nor restore their reputations as secure employers or providers of services to hospital and other clients. *See* Brisman Decl. ¶ 59.

For these reasons, the Practice has met the requirement for establishing irreparable harm to obtain a preliminary injunction at this juncture.

II. PLAINTIFF IS ENTITLED TO THE RELIEF REQUESTED

As demonstrated below, a Preliminary Injunction should be issued as Plaintiff can show a likelihood of success on the merits since the Department has failed to enforce health plan compliance with the No Surprises Act.

A. Failure to Address Health Plan Initial Payment Delays

The No Surprises Act set out, in specific detail, a process wherein both a medical provider and health plan were directed to provide a wide range of relevant data (with few exceptions) for consideration by the IDR entity. Given this balance billing ban imposed on out-of-network providers, very short and specific time frames were set out for the IDR entity to make its determination and for the health plan to make its additional payment if it lost.

Rather than overseeing the IDR process, and providing regulatory enforcement of the law, the Departments, whose interest seem to align almost exactly with that of the nation's giant health plan monopolies, have sabotaged the process, essentially rewriting the law. Indeed, although the No Surprises Act has been in effect for more than 16 months, hardly any IDR claims have been processed.[2] And, the vast majority of those claims that were processed favorably to the Practice by the IDR remain unpaid, in violation of the specific time frames outlined in the Act. *See* Brisman Decl., Exhibit A.

Specifically, the No Surprises Act requires health plans, within 30 calendar days after the out-of-network provider transmits its bill to the health plan, to either make an initial payment to the provider or issue a notice of denial of payment. Unfortunately, the health plans have almost

[2] *See* https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf (last accessed on May 10, 2023).

completely failed to comply with this 30-day timeframe. Because of the balance billing ban imposed by the Act, each day that the health plans fail to comply with the 30-day deadline marks yet another day that the Practice does not get paid *anything* for the medically necessary treatment that it provided the health plan's beneficiaries.

It is hard to imagine a clearer entitlement to relief than a finding by the IDR entity – the authorized entity to resolve these disputes – who finds in favor of the Practice, issues an order directing a health plan to remit additional payment for a covered service, yet the underlying plan fails to honor that obligation.[3] And, making matters worse, also, in direct contravention of the No Surprises Act – particularly 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv) (emergency services), 300gg-111(b)(1)(C) (non-emergency services) – payments, when made by the plan, are often sent directly to the patients. This is yet another example of the Departments' failure to implement the plain requirements of the Act.

B. Substantial IDR Process Delays

Congress also established an open negotiation period between health plans and providers coupled with a balanced IDR process employing tight timeframes and deadlines to ensure that there is a predictable and efficient process designed to enable providers to be reasonably and appropriately reimbursed. However, this is not what has occurred. For example, the Practice's consistent experience during the 14 months that the No Surprises Act has been in effect that health plans have steadfastly refused to engage in meaningful open negotiations with it regarding reimbursement rates, as required by the Act. 42 U.S.C. § 300gg-111(c)(1)(A). Accordingly, virtually every reimbursement claim submitted to the health plans has been forced into the IDR process. Due to the plans' bad faith conduct,

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the statutory 30-day negotiation period has become nothing more than another 30-day delay of reimbursement to the Practice for the medically necessary treatment it provided the plans' beneficiaries. *See* Brisman Decl. ¶ 25.

Additionally, there has been a complete failure by the Departments to follow and observe the tight time frames established in the No Surprises Act for the IDR process. The Act specifically states:

> Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—
>
> (i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and
>
> (ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

42 U.S.C. § 300gg-111(c)(5)(A)(i)-(ii).

Since the IDR process became mandatory in January 2022, the Departments have completely ignored this statutory timeframe. Indeed, it took months after the IDR process became mandatory in January 2022 for the Departments to set up and open the portal that enabled the Practice to initiate the process and submit the required documents. *See* Brisman Decl. ¶ 28. And then, even after the portal opened, there were months on end when the entire process ground to a halt because of successful challenges that were made to the IDR determination methodology established by the Department's regulations. These decisions are *Texas Medical Association. v. United States Department of Health and Human Services*, Case No. 6:21-cv-425 (E.D. Tex. Feb. 23, 2022) (TMA I); *LifeNet, Inc. v. United States Department of Health and Human Services*, Case No. 6:22-cv-162 (E.D. Tex. Jul. 26, 2022) (LifeNet I), and *Texas Medical Association v. United States Department of Health and Human Services*, Case No. 6:22-cv-372 (E.D. Tex. Feb. 6, 2023) (TMA II).

These delays, unfortunately, were only the tip of the iceberg. Even when the IDR process was up and running globally, the overloading of the IDR system – largely due to the number of cases submitted throughout the country, logistical issues with the portal, and the failure to have sufficient IDR entities on board to meet the demand – has meant that the time from submission of all documentation to decision has not even remotely met the statutorily required 30-day deadline. Indeed, virtually all the Practice's IDR proceedings commenced and ready for decision in 1Q and 2Q 2022 remain undecided as of today, more than one year later. *See* Brisman Decl. ¶¶ 30-31. Clearly, the Departments have not taken seriously their statutory obligation to move IDR proceedings to conclusion within the 30-day timeframe. Put simply, the Departments have utterly failed to contribute the required amounts of resources and implement the required level of oversight to comply with this statutory timeframe.

Additionally, one of the biggest causes of IDR process delays is eligibility disputes, where there is an issue between the parties as to whether a particular dispute is eligible for IDR under the No Surprises Act. Unfortunately, these issues are being decided on an *ad hoc* basis with no requirement for an explanation as to the reasons for eligibility or ineligibility. *See* Brisman Decl. ¶ 33. As a result, the Practice, and other similarly situated out-of-network providers, are left in the dark regarding what disputes are, and are not eligible, for IDR. It also appears that plans are making blanket ineligibility claims to delay processing and increase providers' costs. *Id*. at ¶ 34.

For these reasons, the Departments should be compelled, consistent with the letter and spirit of the No Surprises Act, to provide a streamlined process for determining threshold eligibility issues, along with providing an explanation for why a dispute is eligible or ineligible for IDR so as to eliminate this roadblock in the processing system and give the parties a better understanding of what is eligible, thereby reducing the filing of ineligible claims.

C. IDR Roadblocks And Illegal IDR Decision Making Criteria

The Departments have further placed roadblocks in the IDR process that seem designed to favor the plans at the expense of out-of-network providers such as the Practice. These roadblocks include an unwillingness to allow reasonable batching of similar claims, which would make it easier and more efficient for the providers to use the IDR process, and lead to a quicker resolution of claims, as well as persistently clinging to the QPA as essentially a "benchmark" in the IDR process, notwithstanding court decisions that squarely held that such a position is contrary to the purpose and intent underlying the No Surprises Act. *See* Brisman Decl. ¶¶ 37-38. These unfounded decisions by the Departments – all of which favored the plans – has been a major contributor to the current severe delays.

For example, the main thrust of the various court decisions invalidating and vacating various provisions of the Departments' regulations is that those regulations, and the Departments' guidance applying them, place undue, almost talismanic, emphasis on the QPA to the point where there IDR entities were interpreting the regulations to create a rebuttable presumption that the offer closest to the QPA should be adopted as the payment amount. The decisions also rejected the concept that additional non-QPA factors are of lesser importance in the IDR entities' deliberations. *Texas Medical Association. v. United States Department of Health and Human Services*, Case No. 6:21-cv-425 (E.D. Tex. Feb. 23, 2022) (TMA I); *LifeNet, Inc. v. United States Department of Health and Human Services*, Case No. 6:22-cv-162 (E.D. Tex. Jul. 26, 2022) (LifeNet I), and *Texas Medical Association v. United States Department of Health and Human Services*, Case No. 6:22-cv-372 (E.D. Tex. Feb. 6, 2023) (TMA II).

Yet, to this day, notwithstanding these decisions, the Departments are still issuing guidance to IDR entities, and comments on their regulations, which confuse these issues and refer IDR entities and other parties back to guidance documents that are based on the invalidated regulations. Specifically, the Departments, despite the recent losses in the federal lawsuits outlined above, have still not clarified to IDR entities that they are NOT to presume that non-QPA data are "included" or "factored in" the QPA, and, as such, they are NOT to presume that non-QPA data should receive reduced consideration or no consideration as a result.

Moreover, the Department has failed to issue firm guidelines on whether the state surprise billing law controls versus the federal No Surprises Act. The No Surprises Act's IDR process does not apply when a state has a specified state law that meets certain criteria regarding the provision of an alternative IDR process. 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I). New York's specified state law is New York Surprise Bill and Emergency Medical Services Law, codified at article 6 of the New York Financial Services Law. It applies primarily to fully insured health plans in New York where the care underlying the dispute is rendered under circumstances that would meet the definition of a surprise bill or emergency medical services. *See* N.Y. Financial Services Law §§ 601-08. Disputes involving surprise bills and emergency medical services are submitted to a New York IDR process overseen by the New York Department of Financial Services.

The New York Department of Financial Services has consistently taken the position that elective procedures, performed in a hospital, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the hospital that the provider was out-of-network, but chose to proceed anyway, do not fall within the definition of a surprise bill or emergency medical services under article 6 of the Financial Services Law and, accordingly, are not eligible for New York IDR. *See* Brisman Decl. ¶ ¶ 43-45. Accordingly, under the No Surprises Act, those disputes

are therefore subject to federal IDR because there is not a specified state law that applies. 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

However, recently, when the Practice and other similarly situated out-of-network providers have taken these cases to federal IDR, the fully insured health plans, supported by the New York Department of Financial Services, have taken the position that these claims are ineligible for federal IDR under the No Surprises Act because a specified state law applies. *See* Brisman Decl. ¶ ¶ 43-45. Notwithstanding that this is an incorrect interpretation of the law, the federal IDR entities, aided by the Departments, have accepted the plans' arguments, and refused to process these claims through federal IDR.

When the Practice and other similarly situated out-of-network providers attempt to submit these cases to New York IDR, the very same plans, again aided by the New York Department of Financial Services, have taken the infuriatingly inconsistent position that these claims are not eligible for New York IDR because, under New York law, they are neither surprise bills nor emergency medical services claims. *See* Brisman Decl. ¶ 45. Thus, the Practice and other similarly situated out-of-network providers, through the inaction of the Departments, have been left without any avenue to challenge the abysmally low reimbursement provided in the first instance by the plans.

The above demonstrates a clear violation of the APA. Section 706 of the APA states that "[t]he reviewing court shall—(1) **compel agency action unlawfully withheld or unreasonably delayed**; and (2) hold unlawful and set aside agency action, findings, and conclusions found to be," inter alia, "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706. The Departments here, have not only sat idle while health plans skirt their obligations under the No Surprises Act, but have also taken measures to frustrate the Act's intent through their incorrect interpretation of the law.

Moreover, the Departments actions also violate the Takings Clause of the Fifth Amendment, which prevents the seizure of property without just compensation. Here, the Practice is undoubtedly entitled to the additional sums of reimbursement that the IDR entities ordered be paid to the Practice. *See* Brisman Decl., Exhibit A. The Practice had no alternative remedy available at law but to submit these claims to the federal IDR entities for resolution. The Departments' failure to enforce the Act's requirements, including the timeframe for a health plan to pay an adverse IDR award, deprives the Practice of property duly owed to the Practice and constitutes an unconstitutional takings within the Fifth Amendment. *See Lynch v. United States*, 292 U.S. 571, 579 (1934) ("The Fifth Amendment commands that property be not taken without making just compensation. ***Valid contracts are property, whether the obligor be a private individual, a municipality, a State or the United States.***") (emphasis added); *Cienega Gardens v. U.S.*, 331 F.3d 1319, 1334 (Fed. Cir. 2003) (agreements between private parties "give rise to protected property interests, irrespective of whether the subject matter of the contracts is under the government's regulatory jurisdiction.").

At a minimum, this meets the likelihood of success on the merits standard.[4]

III. THE EQUITIES AND PUBLIC INTEREST UNEQUIVOCALLY TIP IN PLAINTIFFS' FAVOR

"Crafting a preliminary injunction is an exercise of discretion and judgment, often dependent as much on the equities of a given case as the substance of the legal issues it presents." *Trump v. Int'l Regugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017) ("Injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the

[4] Plaintiff must only show a likelihood of success and not the higher standard of a "clear or substantial" likelihood of success on the merits (*see Jolly*, supra) because the injunction seeks the enforcement of the Act, rather than alter, the law.

plaintiffs."). In the present case, the balance of equities undoubtedly favors Plaintiff as its business cannot be sustained in an environment where it is unclear if it will ever be paid for services rendered, despite showing a clear entitlement to same. Further, balancing the public interest also favors Plaintiff as the No Surprises Act was enacted to protect patients from large surprise medical bills in exchange for a mechanism that would provide for the fair and fast resolution of reimbursement disputes.

To maintain the status quo in this case is to prevent the Defendants from taking the *ultra vires* acts outlined above, with no statutory support. The utter tragedy here is that all this can be avoided simply by requiring the Departments to enforce the terms of the No Surprises Act. On the balance, Defendants will suffer very little burden. A preliminary injunction will ensure status quo by compelling the Departments to enforce compliance with the No Surprises Act. An injunction will not impose any hardship to Defendants while these important statutory issues are decided and, as a result, the balance of hardships tips decidedly in Plaintiffs' favor to maintain the ability to provide critical health benefits and physician access to its patients.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiff's request for injunctive relief.

Dated: Uniondale, New York
May 11, 2023

HARRIS BEACH, PLLC
Attorneys for Petitioners

By: */s/ Roy W. Breitenbach*
Roy W. Breitenbach
Daniel A. Hallak
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Uniondale, New York 11553
(516) 880-8484

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------X
NEUROLOGICAL SURGERY PRACTICE OF LONG ISLAND, PLLC,

Plaintiff,

-against-

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF THE TREASURY; UNITED STATES DEPARTMENT OF LABOR; XAVIER BECERRA, in his official capacity as Secretary, United States Department of Health and Human Services; JANET YELLEN, in her official capacity as Secretary, United States Department of the Treasury; and JULIE A. SU, in her official capacity as Acting Secretary, United States Department of Labor,

Defendant.
----------X

Case No.: 1:23-cv-2977 (BMC)

DECLARATION OF MICHAEL H. BRISMAN, M.D. IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

MICHAEL H. BRISMAN, M.D., declares under the penalties of perjury and pursuant to 28 U.S.C.§ 1746 that:

1. I am the Chief Executive Officer of the Plaintiff Neurological Surgery Practice of Long Island, PLLC (the "Practice" or "Plaintiff") and am fully familiar with the facts set forth herein.

2. The Practice commenced this lawsuit several weeks ago because, as is explained in detail below, and in the accompanying papers, the Defendants, the federal agencies that Congress charged with enforcing the requirements and procedures of the No Surprises Act have completely abdicated their responsibilities. Since the Practice, and other similarly situated out-of-network neurosurgery providers, are heavily dependent on the fair, effective, and efficient enforcement of

the No Surprises Act and its administrative processes to be reimbursed for providing medically necessary health care services, Defendants' failures are causing the Practice specifically, and other similarly situated out-of-network providers generally, severe and irreparable harm.

3. Accordingly, the Practice has commenced this action challenging the Defendants' actions under the Administrative Procedure Act and the All Writs Act, and now seek a preliminary injunction in an attempt to halt the flow of severe and irreparable harm caused it – and other similarly situated out-of-network providers – by Defendants' improper and illegal actions:

4. Our Practice is one of the largest private neurosurgery practices in the New York metropolitan area. Like many other independent medical specialty groups, we historically chose in most cases not to join health plan networks, because our relatively small size makes it impossible to negotiate acceptable rates. Accordingly, neither the Practice nor our neurosurgeons or other clinicians are health plan participating providers in most cases.

5. Notwithstanding this, we regularly provide medically necessary, covered services on an "out of network" (and often emergency) basis to enrollees of all health plans. Our provision of these services since January 1, 2022, has been governed (in most cases) by the No Surprises Act.

The No Surprises Act

6. As our counsel explains in the accompanying memorandum of law, Congress passed the No Surprises Act in December 2020. Its purpose was to prevent patients from having responsibility for medical bills from non-contracted medical providers with whom their private health plans had failed to reach adequate payment agreements. To solve this problem, medical

providers were required to hold patients harmless for anything above what the patient would have paid for an in-network service.

7. If the provider and health plan could not come to a mutually satisfactory payment amount, Congress created a quick and fair independent dispute resolution (IDR) process, based largely on the "baseball style arbitration" process first created here in New York. The New York process, which started in 2015, demonstrated that this process could be run in a quick, fair, and inexpensive manner.

8. Accordingly, the No Surprises Act set out, in specific detail, a very similar process. Both provider and health plan were directed to provide a wide range of relevant data (with few exceptions) for consideration by the IDR entity. Given this balance billing ban imposed on out-of-network providers, very short and specific time frames were set out for the IDR entity to make its determination and for the health plan to make its additional payment if it lost.

9. Rather than overseeing the IDR process, and providing regulatory enforcement of the law, the Departments, whose interest seem to align almost exactly with that of the nation's giant health plan monopolies, have sabotaged the process, essentially rewriting the law. Indeed, although the No Surprises Act has been in effect for more than 16 months, hardly any IDR claims have been processed.

10. The Departments' unlawful implementation of the No Surprises Act has put the Practice and other similarly situated out-of-network providers jeopardy of imminent financial collapse. This would not only have a disastrous impact on healthcare access, quality, and cost, but also would create significant liabilities for all involved because of the financial damages that these providers sustained as a result of the destruction of their practices due to the Departments acting way beyond any rational authority.

11. In general terms, the Departments' illegal and improper actions and inactions have caused three major problems for the Practice and other similarly situated out-of-network providers:

- The Departments are not processing IDR claims in the required timeframe.
- The Departments are routinely allowing IDR eligible claims to be rejected.
- The Departments are allowing health plans to avoid paying claims they lose at IDR.

12. Immediate relief is needed by this Court to stop the bleeding caused by Defendants' improper and illegal actions.

Failure to Address Health Plan Initial Payment Delays

13. Specifically, the No Surprises Act prohibits out-of-network providers, such as the Practice, from balance billing or otherwise pursuing payments from health plan members. Given this balance billing ban, the Act requires health plans, within 30 calendar days after the out-of-network provider transmits its bill to the health plan, to either make an initial payment to the provider or issue a notice of denial of payment.

14. Unfortunately, the health plans have almost completely failed to comply with this 30-day timeframe. Because of the balance billing ban imposed by the Act, each day that the health plans fail to comply with the 30-day deadline marks yet another day that the Practice does not get paid *anything* for the medically necessary treatment that it provided the health plan's beneficiaries.

15. There is nothing in the Act that allows our Practice to stop or avoid paying for the costs incurred in providing this treatment, so not only is the Practice not receiving any reimbursement for the treatment, but it still must also pay for all costs incurred in rendering that treatment. This, therefore, is an economically untenable situation.

16. The Departments are certainly aware of the health plans' almost complete failure to comply with the 30-day timeframe. Indeed, many complaints have been to the Departments

regarding this issue by health care providers (including us), and physician advocacy organizations. There have also been extensive discussions in the trade press regarding this issue of health plan delays. *See* The Battle for Fair Reimbursement Under The No Surprises Act, *RevCycle Intelligence*, Apr. 3, 2023 (https://revcycleintelligence.com/news/the-battle-for-fair-reimbursement-under-the-no-surprises-act).

17. Regardless, while many complaints have been made to the Departments regarding the plans' failure to honor these statutory timeframes, these complaints have all fallen on deaf ears, creating a situation where the Departments are tacitly, if not expressly, approving the plans' delay tactics and denial of compensation for the medically necessary services provided.

18. Making matters worse, the health plans, when they make payments at all, make them almost always directly to the patients as opposed to the Practice. This conduct by the health plans directly contravenes the No Surprises Act, and unfairly burdens the Practice with having to retrieve the payment from the patients, resulting in delays and a resulting inability to honor the Practice's timeframes under the No Surprises Act.

19. There are many more problems with the health plans' initial communications regarding payment. For example, the Departments have failed to require health plans to clearly state on their explanation of benefit (EOB) forms their understanding of whether the case is IDR eligible and in which venue (federal or state). This would immediately reduce the problem of health plans declaring numerous cases to be "ineligible." IDR entities are routinely dismissing cases just because health plans declare them to be ineligible, which health plans declare regularly, and usually, incorrectly.

20. Likewise, the Departments have not required health plans to present an exact value of their QPA in the EOB. This has also made it difficult to process the cases at IDR. The Departments also

have not required a quick and easy and accurate process for medical providers to ask questions and resolve issues related to the IDR process. It is impossible for medical providers to reach CMS or the IDR entities by phone, and emails are responded to very slowly and often, with inaccurate responses. Among other things, this makes it very hard for medical practices to comply with the strict timeline requirements set out in the law.

Substantial IDR Process Delays

21. There is no incentive for the health plans to provide anything but a *de minimis* initial payment, because, given the current delays in the IDR process, it will be many months, if not years, before there is any realistic chance for them to be held to account for their initial low payment. It is no doubt in their view that it far better to retain the appropriate reimbursement funds in their coffers – and thereby pressure the Practice and other similarly situated providers to accept low in-network rates – than to pay a reasonably appropriate amount in the first instance to providers such as the Practice.

22. One of the biggest problems facing the Practice and other similarly situated providers is the long delays and uncertainty in the IDR process. Congress established an open negotiation period between health plans and providers coupled with a balanced IDR process employing tight timeframes and deadlines to ensure that there is a predictable and efficient process designed to enable providers to be reasonably and appropriately reimbursed. However, this is not what has occurred.

23. For example, the Practice's consistent experience during the 14 months that the No Surprises Act has been in effect that health plans have steadfastly refused to engage in meaningful open negotiations with it regarding reimbursement rates, as required by the Act.

24. Indeed, a recent study by the Emergency Department Practice Management Association reported that 68% of filed IDR claims in 2022 did not receive replies from health plans during the 30-

day open negotiation period. Further, 52% of payers did not acknowledge that an IDR claim had been filed, and 75% of payers who actually responded in the IDR process made no actionable offers. *See* Data Analysis: No Surprises Act Independent Dispute Resolution Effectiveness, *EDPMA* (https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf).

25. Accordingly, virtually every reimbursement claim submitted to the health plans has been forced into the IDR process. Due to the plans' bad faith conduct, the statutory 30-day negotiation period has become nothing more than another 30-day delay of reimbursement to the Practice for the medically necessary treatment it provided the plans' beneficiaries.

26. The Departments are certainly aware of the health plans' bad faith negotiating practices yet, have failed to address this issue and compel the Plans to act in good faith and in compliance with their statutory obligations.

27. Additionally, there has been a complete failure by the Departments to follow and observe the tight time frames established in the No Surprises Act for the IDR process. The Act specifically requires that IDR decisions be issued no later than 30 days after the IDR process begins with the selection of an IDR entity.

28. Since the IDR process became mandatory in January 2022, the Departments have completely ignored this statutory timeframe. Indeed, it took months *after* the IDR process became mandatory in January 2022 for the Departments to set up and open the portal that enabled the Practice to initiate the process and submit the required documents. And then, even after the portal opened, there were months on end when the entire process ground to a halt because of successful challenges that were made to the IDR determination methodology established by the Department's regulations.

29. It was only on February 23, 2023 that the Departments instructed IDR entities to

resume processing payment determinations (effective February 27, 2023).

30. These delays, unfortunately, are only the tip of the iceberg. Even when the IDR process was up and running globally, the overloading of the IDR system – largely due to the number of cases submitted throughout the country, logistical issues with the portal, and the failure to have sufficient IDR entities on board to meet the demand – has meant that the time from submission of all documentation to decision has not even remotely met the statutorily required 30-day deadline.

31. Indeed, virtually all the Practice's IDR proceedings commenced and ready for decision in 1Q and 2Q 2022 remain undecided as of today, *more than one year later*. The proof is in the numbers: the EDPMA study reports that, as of March 2023, fully 91% of the IDR proceedings initiated in 2022 remained undecided! *See* Data Analysis: No Surprises Act Independent Dispute Resolution Effectiveness, *EDPMA* (https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf).

32. Clearly, the Departments have not taken seriously their statutory obligation to move IDR proceedings to conclusion within the 30-day timeframe. Put simply, the Departments have utterly failed to contribute the required amounts of resources and implement the required level of oversight to comply with this statutory timeframe.

33. Additionally, one of the biggest causes of IDR process delays is eligibility disputes, where there is an issue between the parties as to whether a particular dispute is eligible for IDR under the No Surprises Act. Unfortunately, these issues are being decided on an *ad hoc* basis with no requirement for an explanation as to the reasons for eligibility or ineligibility.

34. As a result, the Practice, and other similarly situated out-of-network providers, are left in the dark regarding what disputes are, and are not eligible, for IDR. It also appears that plans

are making blanket ineligibility claims to delay processing and increase providers' costs.

35. For these reasons, the Departments should, consistent with the letter and spirit of the No Surprises Act, be required to provide a streamlined process for determining threshold eligibility issues, along with providing an explanation for why a dispute is eligible or ineligible for IDR to eliminate this roadblock in the processing system and give the parties a better understanding of what is eligible, thereby reducing the filing of ineligible claims.

IDR Roadblocks

36. Additionally, the Departments have also placed roadblocks in the IDR process that seem designed to favor the plans at the expense of out-of-network providers such as the Practice.

37. These roadblocks include an unwillingness to allow reasonable batching of similar claims, which would make it easier and more efficient for the providers to use the IDR process, and lead to a quicker resolution of claims, as well as persistently clinging to the QPA as essentially a "benchmark" in the IDR process, notwithstanding court decisions that squarely held that such a position is contrary to the purpose and intent underlying the No Surprises Act.

38. These unfounded decisions by the Departments – all of which favored the plans – has been a major contributor to the current severe delays. The irony is that, had the Department simply fully and fairly implemented the IDR process in accordance with Congressional intent and the plain language of the No Surprises Act, the process would currently be working efficiently and many of the delays would be eliminated. The Departments are also fully aware that IDR process delays grievously injure out-of-network providers by denying them access to reimbursements, yet they have done nothing to move the process along.

39. This has had a direct and significantly negative effect on us and other similarly situated out-of-network providers.

40. As alleged above, health plans have delayed and lowballed initial payments to providers required by the Act, and the Act bars providers from balance billing or otherwise seeking payment from plan beneficiaries. This has made the Practice and other similarly situated out-of-network providers entirely dependent on the timely and efficient conclusion of the IDR process to receive reimbursement for the medically necessary services that they provided plan beneficiaries.

41. These delays in reimbursement-claim proceeding through the IDR process has had the effect of almost completely shutting down reimbursement to the Practice and other similarly situated out-of-network providers. No practice can survive long without reimbursement, particularly where, as here, its expenses not only continue but have significantly increased.

Ping Ponging Between NY and NSA IDR Processes

42. The No Surprises Act's IDR process does not apply when a state has a specified state law that meets certain criteria regarding the provision of an alternative IDR process. New York's specified state law is New York Surprise Bill and Emergency Medical Services Law. It applies primarily to fully insured and other state regulated health plans in New York where the care underlying the dispute is rendered under circumstances that would meet the definition of a surprise bill or emergency medical services. Disputes involving surprise bills and emergency medical services are submitted to a New York IDR process overseen by the New York Department of Financial Services.

43. The New York Department of Financial Services has historically taken the position that elective procedures, performed in a hospital, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the hospital that the provider was out-of-network, but chose to proceed anyway, do not fall within the definition of a surprise bill and are therefore not eligible for New York IDR. Accordingly, under the No Surprises Act, those disputes are therefore subject to federal IDR because there is not a specified state law that applies.

44. However, recently, when we and other similarly situated out-of-network providers have taken these cases to federal IDR, the fully insured health plans, supported by the New York Department of Financial Services, have taken the position that these claims are ineligible for federal IDR under the No Surprises Act because a specified state law applies. Notwithstanding that this is an incorrect interpretation of the law, the federal IDR entities, aided by the Departments, have accepted the plans' arguments, and refused to process these claims through federal IDR.

45. When we have attempted to submit these cases to New York IDR, the very same plans, again aided by the New York Department of Financial Services, have taken the infuriatingly inconsistent position that these claims are not eligible for New York IDR because, under New York law, they are neither surprise bills nor emergency medical services claims. Thus, through the inaction of the Departments, we have been left without any avenue to challenge the abysmally low reimbursement provided in the first instance by the plans.

Refusal to Honor Additional Payment Obligations

46. Additionally, even in cases where the IDR process has come to a favorable decision for us – long after the required 30-day timeframe – we still in most cases have not received the required additional reimbursement from the health plans.

47. Specifically, under the Act, when the IDR entity has decided the IDR dispute by selecting the Practice's offer, the plans have 30 days from the date on which the IDR entity makes its determination to pay the additional reimbursement due the Practice.

48. There have been many claims involving medical services provided by the Practice to enrollees of the plans for which (a) an IDR proceeding was commenced; (b) the duly appointed IDR entity, after reviewing the parties' offers and submissions, selected the Practice's offers, resulting in an additional reimbursement due from the plans to the Practice; (c) more than 30 days have elapsed since the IDR entity made these determinations; yet (d) the plans have breached their statutory obligation to pay these additional reimbursement amounts.

49. Making matters worse, the plans have persisted in failing to pay these additional, statutorily ordered reimbursement amounts notwithstanding numerous attempts by the Practice to have the plans honor their obligations. As the correspondence plainly shows, the Departments are certainly aware of the health plans' almost complete failure to comply with the 30-day timeframe. *See* Exhibit A. Indeed, many complaints have been to the Departments regarding this issue by health care providers (including the Practice), and physician advocacy organizations. There have also been extensive discussions in the trade press regarding this issue of health plan delays.

50. Indeed, the EDPMA study reports that, during 2022, 87 percent of payers did not pay in accordance with the IDR determination. *See* Data Analysis: No Surprises Act Independent Dispute Resolution Effectiveness, *EDPMA* (https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf).

51. As a result of all of this, most of the Practice's very few IDR proceedings that have been adjudicated in 2022 remain unpaid as of today, more than one year later after the Practice provided those services. Clearly, the Departments have not taken seriously their statutory obligation to move IDR proceedings to conclusion within the 30-day timeframe. Put simply, the Departments have utterly failed to contribute the required amounts of resources and implement the required level of oversight to comply with this statutory timeframe.

52. The small representative sample of claims correspondence with the IDR entities (*see* Exhibit A) demonstrates the untenable situation caused by the Departments' inaction. These eight claims – adjudicated months ago – amount to $262,134.00 that has not been reimbursed to the Practice.

53. Of course, the obligations of the Practice to render medically necessary care and to incur and pay for the ever-increasing costs of providing that care continue unabated during this process; the only thing that has changed is that the Practice is not receiving anything more than far-below cost, minimal reimbursement for providing that care.

Irreparable Harm Suffered by the Practice and the Public At Large

54. By reason of all the foregoing, the Practice, and other similarly situated out-of-network providers, have been grievously and irreparably harmed.

55. As alleged above, under the No Surprises Act, out-of-network providers such as the Practice are forbidden from balance billing patients after providing those patients with medically necessary health care services. Relatedly, the No Surprises Act allows health plans to unilaterally determine the amount of reimbursement they pay in the first instance to those providers for the

medically necessary health care services that the providers render to the plans' members. Abusing this unilateral power, many health plans are initially reimbursing us, and other similarly situated out-of-network providers, at minimal rates far below what these providers received before the effective date of the No Surprises Act. These reimbursement rates are also significantly below the providers' costs of delivering the medically services, as well as far below the usual, customary, and reasonable rates for the services established by the industry standard benchmarking services.

56. Given these circumstances, the Practice, and other similarly situated out-of-network providers, are heavily dependent upon the effectiveness, timeliness, and efficiency of the federal IDR process established by the No Surprises Act to "level the playing field" with the plans, and ensure that the providers receive if not reasonable compensation for their services, at least compensation for their services that covers the costs for providing those services.

57. Unfortunately, as outlined above, the Departments have failed to honor their statutory obligations under the No Surprises Act and have thereby destroyed the timeliness, effectiveness, and efficiency of the federal IDR process. As a consequence, the Practice, and other similarly situated out-of-network providers, have been forced to wait now for more than a year to receive anything but minimal, far-below-cost reimbursement for the medically necessary services that they provided. The inefficiencies of the federal IDR process – created by the Departments' inactions and actions outlined above – have also greatly increased the providers' revenue cycle costs, at a time when reimbursements have been drastically cut.

58. As a result of the foregoing, the Practice, and other similarly situated out-of-network providers, have suffered significant and irreparable injury. They have been forced to confront a situation where, due to of the Departments' actions, their reimbursements have been

drastically reduced and delayed, at the same time that their costs for providing their medically necessary services have significantly risen.

59. No business – much less an independent medical practice in one of the most expensive regions of the country – can long sustain such financial difficulties. The Practice, and other similarly situated out-of-network providers, accordingly, have been forced to curtail and, in many cases, eliminate services, reduce the acquisition of new equipment, and hold off hiring additional or replacement clinicians and support personnel.

60. Some out-of-network providers have already gone out of business. If the current situation regarding the timeliness, effectiveness, and efficiency of the federal IDR process is allowed to continue, many more providers will have their businesses and livelihoods destroyed due to the Departments' actions and inactions, as outlined above.

61. In addition to damaging the providers, this will have the far greater impact of reducing the availability of high-quality and timely medically necessary health care services for the public.

62. There is no adequate remedy at law for these irreparable injuries. While monetary damages may make up for lost revenue as a result of the Departments actions, the Practice's patients – and those patients of other similarly situated out-of-network providers – will suffer the loss of continuity of medical care, significant delays in the provision of care due to the lack of or restricted access to out-of-network physicians, potential exposures to surprise and balance bills, and significant increases in adverse health outcomes, including serious illness and the potential loss of life.

Conclusion

63. Due to the above, the Practice respectfully requests that this Court grant its motion for

preliminary injunction, mandating that Defendants, during the pendency of this lawsuit:

a. Direct health plans subject to the No Surprises Act to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan, and enforce compliance with this direction;

b. Direct health plans subject to the No Surprises Act to make all initial payments under the No Surprises Act to the out-of-network providers who rendered the medical services, as opposed to the patients, and monitor compliance with this direction;

c. Direct health plans subject to the No Surprises Act to ensure that (i) the explanation of benefits (EOB) forms required by the No Surprises Act be sent to the out-of-network providers who rendered the medical services; (ii) these EOBs clearly indicate the issuing health plan's understanding whether the case is eligible for independent dispute resolution (IDR) under either federal or state law; and (iii) the EOBs report the health plans' proposed qualified payment amount (as defined according to the No Surprises Act) for each CPT code reflected on the EOB, and monitor compliance with these directions.

d. Devote sufficient monetary and other resources required to ensure that the IDR process time frames established by the No Surprises Act are complied with;

e. Direct health plans to take all steps necessary to ensure that the IDR process time frames established by the No Surprises Act are complied with, and monitor compliance with these directions;

f. Establish a streamlined process for determining threshold eligibility issues, along with providing an explanation for why a dispute is eligible or ineligible for IDR to eliminate roadblocks in the IDR processing system;

g. Allow a reasonable batching of similarly situated IDR claims;

h. Follow the provisions of the No Surprises Act and require that reimbursement disputes relating to elective procedures performed in a New York state-located hospital, by an out-of-network provider, on a fully insured or otherwise state regulated health plan beneficiary, who was aware before he or she came to the hospital that the provider was out of network, but chose to proceed anyway, be accepted by and decided through federal IDR process;

i. Direct health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the No Surprises Act, and monitor compliance with this direction; and

j. Require Defendants to provide a status report to the Court weekly regarding Defendants' compliance with this Order:

I declare under penalties of perjury that the foregoing is true and correct.

Dated: Uniondale, New York
May 10, 2023

Michael H. Brisman, M.D.

Exhibit A

Roxann Rampersad AIDU DE LEONARDIS

From: IDRInquiry <IDRInquiry@c2cinc.com> CODE · 01510 ·
Sent: Wednesday, November 30, 2022 5:12 PM
Subject: Written Payment Determination Notice: DISP-95982

Follow Up Flag: Follow up
Flag Status: Flagged

IDR dispute status: Payment determination made
IDR reference number: DISP-95982
Initiating Party Name: DR. RAMIN RAK MD

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-95982** and determined:

The out-of-network payment amount of **$33,860.00** offered by **DR. RAMIN RAK MD** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• The IDR entity determined the initiating party prevailed. The IDR entity requested the offer and fee payments on October 18, 2022. However, the offer and fee payments were not received from the non-initiating party. As noted in the Federal IDR Process Guidance for Disputing Parties, April 2022, if the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process. This information must be provided no later than one business day after the end of the three-business-day period for certified IDR entity selection, (the same date that the notice of selection or of failure to select a certified IDR entity must be submitted). This notification must include information regarding the Federal IDR Process' inapplicability. In this instance, the non-initiating party failed to timely object to the applicability of the Federal IDR Process. The failure to object is considered implied acceptance. An offer was received from the initiating party for $33,860.00 for craniotomy for excision of tumor (61510). We are only able to consider the offer submitted by the initiating party to make a final determination. Therefore, the IDR entity determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UMR** is the non-prevailing party in **DISP-95982** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee in the amount of **$299** to **DR. RAMIN RAK MD** within 30 business days of the date of this notification.

Pursuant to Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process, **DR. RAMIN RAK MD**, may not submit a subsequent Notice of IDR Initiation involving the same other party, **UMR**, with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation during the 90-calendar-day suspension period following the date of this email, also referred to as a "cooling off" period.

If the end of the open negotiation period for such an item or service falls during the cooling off period, either party may submit the Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard four-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources:

Visit the No Surprises website for additional IDR resources.

Contact information:

For questions, contact C2C at IDRInquiries@c2cinc.com. Include your IDR reference number above.

Thank you,
C2C Innovative Solutions, Inc. (IDREApp-067)

The No Surprises Act establishes a Federal Independent Dispute Resolution (IDR) process for payment disputes between plans and issuers, and providers, facilities, or providers of air ambulance services that may seek a determination from an independent third party certified by the Departments of Health and Human Services, Labor, and the Treasury (the Departments). The Departments have certified C2C Innovative Solutions, Inc. (IDREApp-067) as a certified IDR entity to make this independent determination.

If you have questions, email: IDRInquiries@c2cinc.com

Or call the Federal No Surprises Help Desk: 1-800-985-3059

Or visit: https://www.cms.gov/nosurprises

communication in error, please notify the sender immediately and permanently destroy/delete this email, fax, and/or any attachments. Thank you.

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Thursday, February 2, 2023 11:46 AM
Subject: Written Payment Determination Notice: DISP-167997

IDR dispute status: Payment determination made
IDR reference number: DISP-167997
Initiating Party Name: DR JEFFREY BROWN

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-167997** and determined:

The out-of-network payment amount of **$40,000.00** offered by **DR JEFFREY BROWN** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• At issue is payment for repair procedures on the skull, meninges, and brain (62140).

45 Code of Federal Regulations (CFR) Section 149.510, sets forth that offers must be submitted not later than 10 business days after the selection of the certified IDR entity (IDRE). The plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDRE an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount.

IDR Guidance for Certified IDREs (October 2022) details that if, by the deadline for the parties to submit offers, one party has not submitted an offer, the certified IDRE will select the other party's offer as the final payment amount.

The IDRE requested the offer and fee payments on December 20, 2022. However, the offer and fee payments were not received from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $40,000.00 for code 62140. The IDRE determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UMR** is the non-prevailing party in **DISP-167997** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee in the amount of **$299** to **DR JEFFREY BROWN** within 30 business days of the date of this notification.

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Thursday, February 2, 2023 11:47 AM
Subject: Written Payment Determination Notice: DISP-168039

IDR dispute status: Payment determination made
IDR reference number: DISP-168039
Initiating Party Name: DR JEFFREY BROWN

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-168039** and determined:

The out-of-network payment amount of **$25,000.00** offered by **DR JEFFREY BROWN** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• At issue is payment for repair and/or reconstruction of surgical defects of skull base procedures (61618).

45 Code of Federal Regulations (CFR) Section 149.510, sets forth that offers must be submitted not later than 10 business days after the selection of the certified IDR entity (IDRE). The plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDRE an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount.

IDR Guidance for Certified IDREs (October 2022) details that if, by the deadline for the parties to submit offers, one party has not submitted an offer, the certified IDRE will select the other party's offer as the final payment amount.

The IDRE requested the offer and fee payments on December 20, 2022. However, the offer and fee payments were not received from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $25,000.00 for code 61618. The IDRE determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UMR** is the non-prevailing party in **DISP-168039** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee in the amount of **$299** to **DR JEFFREY BROWN** within 30 business days of the date of this notification.

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Wednesday, February 1, 2023 7:59 PM
Subject: Written Payment Determination Notice: DISP-168083

IDR dispute status: Payment determination made
IDR reference number: DISP-168083
Initiating Party Name: DR JEFFREY BROWN

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-168083** and determined:

The out-of-network payment amount of **$33,000.00** offered by **DR JEFFREY BROWN** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• At issue is payment for operating microscope procedures (69990).

45 Code of Federal Regulations (CFR) Section 149.510, sets forth that offers must be submitted not later than 10 business days after the selection of the certified IDR entity (IDRE). The plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDRE an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount.

IDR Guidance for Certified IDREs (October 2022) details that if, by the deadline for the parties to submit offers, one party has not submitted an offer, the certified IDRE will select the other party's offer as the final payment amount.

The IDRE requested the offer and fee payments on December 19, 2022. However, the offer and fee payments were not received from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $33,000.00 for code 69990. The IDRE determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UMR** is the non-prevailing party in **DISP-168083** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee in the amount of **$299** to **DR JEFFREY BROWN** within 30 business days of the date of this notification.

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Wednesday, December 28, 2022 5:03 PM
Subject: Written Payment Determination Notice: DISP-114942

IDR dispute status: Payment determination made
IDR reference number: DISP-114942
Initiating Party Name: DR ZACHARIAH GEORGE MD

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-114942** and determined:

The out-of-network payment amount of **$434.00** offered by **DR ZACHARIAH GEORGE MD** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• At issue is payment for fluoroscopy (76000).

45 Code of Federal Regulations (CFR) Section 149.510, sets forth that offers must be submitted not later than 10 business days after the selection of the certified IDR entity (IDRE). The plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDRE an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount.

IDR Guidance for Certified IDREs (October 2022) details that if, by the deadline for the parties to submit offers, one party has not submitted an offer, the certified IDRE will select the other party's offer as the final payment amount.

The IDRE requested the offer and fee payments on November 15, 2022. However, the offer and fee payments were not received from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $434.00 for code 76000. The IDRE determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UNITED HEALTHCARE** is the non-prevailing party in **DISP-114942** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee in the amount of **$299** to **DR ZACHARIAH GEORGE MD** within 30 business days of the date of this notification.

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Monday, December 5, 2022 1:53 PM
Subject: Written Payment Determination Notice: DISP-96427

IDR dispute status: Payment determination made
IDR reference number: DISP-96427
Initiating Party Name: DR ZACHARIAH GEORGE MD

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-96427** and determined:

The out-of-network payment amount of **$31,000.00** offered by **DR ZACHARIAH GEORGE MD** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• The IDR entity determined the initiating party prevailed. The IDR entity requested the offer and fee payments on October 21, 2022. However, the offer and fee payments were not received from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $31,000.00 for neuroplasty procedures on the extracranial nerves, peripheral nerves, and autonomic nervous system (64714). The IDR entity determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UNITED HEALTHCARE** is the non-prevailing party in **DISP-96427** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee in the amount of **$299** to **DR ZACHARIAH GEORGE MD** within 30 business days of the date of this notification.

Pursuant to Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process, **DR ZACHARIAH GEORGE MD**, may not submit a subsequent Notice of IDR Initiation involving the same other party, **UNITED HEALTHCARE** , with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation during the 90-calendar-day suspension period

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Friday, December 9, 2022 3:05 PM
Subject: Written Payment Determination Notice: DISP-101336

Flag Status: Flagged

IDR dispute status: Payment determination made
IDR reference number: DISP-101336
Initiating Party Name: DR. ZACHARIAH GEORGE MD

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-101336** and determined:

The out-of-network payment amount of **$40,300.00** offered by **DR. ZACHARIAH GEORGE MD** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• At issue is payment for anterior or anterolateral approach technique arthrodesis procedures on the spine (22552-62).

45 Code of Federal Regulations Section 149.510, sets forth that offers must be submitted not later than 10 business days after the selection of the certified IDR entity (IDRE). The plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDRE an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount.

IDR Guidance for Certified IDREs (October 2022) details that if, by the deadline for the parties to submit offers, one party has not submitted an offer, the certified IDRE will select the other party's offer as the final payment amount.

The IDRE requested the offer and fee payments on October 27, 2022. However, the IDRE did not receive payment from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $40,300.00 for code 22552-62. Therefore, the IDRE determined the initiating party prevailed.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services,** the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **If the plan or issuer is owed a refund,** the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

• NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. C2C has determined that **UNITED HEALTHCARE** is the non-prevailing party in **DISP-101336** and is responsible for paying the certified IDR entity fee. C2C will refund the certified IDR entity fee

zjackson@nspc.com

From: IDRInquiry <IDRInquiry@c2cinc.com>
Sent: Monday, November 21, 2022 7:03 PM
Subject: Written Payment Determination Notice: DISP-82875

IDR dispute status: Payment determination made
IDR reference number: DISP-82875
Initiating Party Name: DR ZACHARIAH GEORGE MD

C2C Innovative Solutions, Inc. (C2C) has reviewed your Independent Dispute Resolution (IDR) dispute with reference number **DISP-82875** and determined:

The out-of-network payment amount of **$58,900.00** offered by **DR ZACHARIAH GEORGE MD** under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

• The IDR entity determined the initiating party prevailed. The IDR entity requested the offer and fee payments on October 10, 2022. However, the offer and fee payments were not received from the non-initiating party. As a result, we are only able to consider the offer submitted by the initiating party to make a final determination. An offer was received from the initiating party for $58,900.00 for an arthrodesis procedures on the spine (vertebral column), anterior or anterolateral approach (22551). The IDR entity determined the initiating party prevailed.

After review, C2C Innovative Solutions, Inc. has determined that this dispute was incorrectly batched.

Properly batched items and services may be submitted and considered jointly (i.e., "batched"). Qualified IDR items and services are considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) with modifiers, if applicable, or Diagnosis-Related Group (DRG) codes with modifiers, if applicable, and all the qualified IDR items and services were furnished within the same 30-business-day period.

C2C Innovative Solutions, Inc. will process for code 22551 with this dispute.

Next Steps:

You may resubmit the additional codes by completing a Notice of IDR Initiation web form and resubmitting items and services as outlined in the tables below.

When completing each Notice of IDR Initiation web form:

Upload this email to the Payment Information section for each claim you submit, in addition to uploading the QPA and any other documents you wish to upload with the claim. The QPA and this email must be attached with each claim.

Select C2C Innovative Solutions, Inc. as your preferred certified IDR entity, which is the same certified IDR entity previously selected for dispute.

If you select a different certified IDR entity, the case will be reassigned to the same certified IDR entity previously selected.

Visit the No Surprises website for additional IDR resources.

Contact information:

For questions, contact C2C at IDRInquiries@c2cinc.com. Include your IDR reference number above.

Thank you,
C2C Innovative Solutions, Inc. (IDREApp-067)

The No Surprises Act establishes a Federal Independent Dispute Resolution (IDR) process for payment disputes between plans and issuers, and providers, facilities, or providers of air ambulance services that may seek a determination from an independent third party certified by the Departments of Health and Human Services, Labor, and the Treasury (the Departments). The Departments have certified C2C Innovative Solutions, Inc. (IDREApp-067) as a certified IDR entity to make this independent determination.

If you have questions, email: IDRInquiries@c2cinc.com

Or call the Federal No Surprises Help Desk: 1-800-985-3059

Or visit: https://www.cms.gov/nosurprises